

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-018855

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 360 Primary Registration District No. 3076 Registrar's No. 74

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

FILED APR 25 1963

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Vernon</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Nevada</u>		c. CITY OR TOWN <u>Nevada</u>	
Length of stay in 1b <u>78 years</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Nevada Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>510 East Walnut</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROY</u> Middle <u>PALMER</u> Last <u>SCHNORF</u>		4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1963</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Wh</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-16-1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soda Bottling Company</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11a. FATHER'S NAME <u>James P. Schnorf</u>		11b. MOTHER'S MAIDEN NAME <u>Mollie Hutchins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>[REDACTED]</u>	
13a. NAME OF HUSBAND OR WIFE <u>Ella Brown Schnorf, Decd.</u>		14. NAME OF HUSBAND OR WIFE <u>1948</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Decompensation</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>1 1/2 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Mechanical intestinal obstruction</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>[REDACTED]</u> Month, Day, Year <u>[REDACTED]</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u>Nevada</u> COUNTY <u>Nevada</u> STATE <u>Missouri</u>	
21. I attended the deceased from <u>3/15/60</u> to <u>4/14/63</u> and last saw him alive on <u>4/14/63</u>		Death occurred at <u>3:40</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>[Signature]</u> (Degree or title)		22b. ADDRESS <u>Nevada, Mo.</u>	
22c. DATE SIGNED <u>4/14/63</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>April 22</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Newton Burial Park</u>	
23d. LOCATION (City, town, or county) <u>Nevada</u>		23e. STATE <u>Missouri</u>	
24. FUNERAL DIRECTOR <u>Ferry Funeral Home</u> ADDRESS <u>Nevada, Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>4-23-1963</u>	
26. REGISTRAR'S SIGNATURE <u>[Signature]</u>		27. DATE SIGNED <u>4/23/63</u>	

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*L. Anglin Ferry*

Licensed Embalmer No.

4960

P. O. Address

Nevada, Missouri

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.